Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. M
Midlands Prison
27 June 2022

Submitted to Minister: 23 October 2024

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GLOSSARY

ACO	Assistant Chief Officer
AG	Assistant Governor
CNO	Chief Nurse Officer
CO	Chief Officer
DiC	Death in Custody
HCA	Health Care Assistant
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PO	Prison Officer
PGH	Portlaoise General Hospital
PHMS	Prisoner Healthcare Management System

INTRODUCTION

1. Preface

1.1 The Office of the Inspector of Prisons (OIP) was established under the Prisons Act 2007 (the Act). Since 2012, the Chief Inspector of Prisons has been obliged to investigate all deaths in prison custody.This includes the death of any person which occurs within one month of their temporary release from prison custody. The OIP also carries out regular inspections of prisons. The Office is independent of the Irish Prison Service (IPS).The Chief Inspector of Prisons and the staff of the OIP are independent of the Department of Justice in the performance of their statutory functions.

1.2 The OIP can make recommendations for improvement where appropriate. Our investigation reports are published by the Minister for Justice, subject to the provisions of the Act, in order that investigation findings and recommendations can be disseminated in the interest of public transparency, to promote best practice in the care of prisoners.

2. Objectives

2.1 The objectives of investigations of deaths in custody are to:

- Establish the circumstances and events surrounding the death, including the care provided by the IPS;
- Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in the future;
- Ensure that the prisoner's family have an opportunity to raise any concerns they may have and take these into account in the investigation; and
- Assist the Coroner's investigation and contribute to meeting the State's obligations under Article 2 of the European Convention on Human Rights, by ensuring, as far as possible, that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified and any lessons from the death are learned.

3. Methodology

3.1 Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, next of kin (NoK); analysis of prison records in relation to the deceased's life while in custody; and examination of evidence, such as CCTV footage and phone calls.

3.2 This report is structured paying particular focus to the care that was afforded to Mr. M during his time in prison.

4. Administration of Investigation

4.1 On 27 June 2022, the OIP was notified that Mr. M had passed away while in the Midlands Prison. On 28 June 2022, the investigation team attended the prison and met prison management who provided an overview of Mr. M's time in prison.

4.2 Midlands Prison Management provided the investigation team with all relevant information in accordance with the standardised checklist of required information.

4.3 The cause of death is a matter for the Coroner.

5. Family Liaison

5.1 Liaison with the deceased's family is a very important aspect of the Inspectorate of Prisons' role when investigating a death in custody.

5.2 The investigation team had difficulty contacting Mr. M's NoK (his widow). On 17 August 2022, a call was made to the NoK which was not answered. Two letters were then sent to the NoK, the first letter was issued on 18 August 2022 and a follow-up letter issued on 12 October 2022. The OIP did not receive a response to these letters. Prior to finalising the investigation report, further efforts were made to contact the NoK and, following a number of telephone calls, the investigation team finally met with the NoK on 21 September 2023.

5.3 The NoK had no concerns or questions. The NoK signed a consent form allowing the investigation team to access and review Mr. M's prison medical records.

5.4 Although this report is for the Minister for Justice, it may also inform several interested parties. It is written primarily with Mr. M's NoK in mind.

5.5 The OIP is grateful to Mr. M's widow for her contributions to this investigation and we offer our sincere condolences on her loss.

6. Midlands Prison

6.1 Midlands Prison is a closed, medium security prison for adult males. It is the committal prison for counties Carlow, Kildare, Kilkenny, Laois, Meath, Monaghan, Offaly, Westmeath, Wexford and Wicklow. At the time of Mr. M's passing, it had an operational capacity of 845.

6.2 Mr. M was the seventh death of a prisoner from the Midlands Prison in 2022 and the thirteenth death in IPS custody that year which met the criteria for investigation by the OIP.

7. Background

7.1 Mr. M was 77 years old when he passed away in the Midlands Prison on 27 June 2022.

7.2 On 16 December 2019, Mr. M was committed to Cloverhill Prison on remand, pending sentence.

7.3 At the High Court, on 15 June 2020, the Court imposed sentences for a number of offences, ranging from 2 years to 20 years, with all sentences to run concurrently from 13 December 2019. Mr. M had a remission date of 11 December 2034.

7.4 On 17 December 2019, Mr. M was transferred from Cloverhill Prison to the Midlands Prison and accommodated in a single cell on G1 landing.

7.5 During the early part of the Covid-19 pandemic, Mr. M was 'cocooned' on G wing and his meals and medication were brought to his cell.

7.6 Mr. M was on the standard level of the Incentivised Regime[1] until the time of his death.

7.7 During his time in custody, Mr. M was diagnosed with a terminal illness and the internal and external movement history recorded that he had attended several hospital appointments during his time in custody.

7.8 As Mr. M's health deteriorated, he had the support of Health Care Assistants (HCA) with his daily personal and hygiene needs. It is recorded that the Prison Palliative Care Team provided end of life care to Mr. M.

[1] There are three levels of regime – basic, standard and enhanced, with different privileges associated with each regime level. All prisoners enter the system at standard regime level and have the opportunity to become eligible for the enhanced regime status once they have met the required criteria for the preceding two months. Incentivised regimes (irishprisons.ie).

8. Medical and Healthcare

8.1 CNO A informed the investigation team that Mr. M had health issues on committal. In August 2021, Mr. M became acutely unwell on G1 landing and was transferred to Portlaoise General Hospital (PGH) where he was diagnosed with pneumonia. Further medical investigation confirmed that he had lung cancer which was not treatable.

8.2 Mr. M was discharged from PGH back to Midlands Prison on 6 September 2021. It is recorded that a special mattress and a bed were ordered for his comfort and protection of his skin.

8.3 Mr. M received full assistance with all his personal and hygiene needs from the HCAs.

8.4 In early November 2021, Mr. M was transferred to PGH with a chest infection and was diagnosed as Covid-19 positive. On recovery, he returned to Midlands Prison on 18 November 2021.

8.5 The Prisoner Healthcare Management System (PHMS) recorded that Mr. M had full assistance with all his personal and hygiene needs by the HCAs.

8.6 Over the following months, Mr. M's general condition continued to deteriorate and the Palliative Care Team was involved in his end of life care.

8.7 Prison cells are usually master locked (double locked) each night but, as Mr. M's health deteriorated, prison management informed the investigation team that Mr. M's cell remained unlocked to facilitate the attendance of the HCAs during the night. Records examined by the investigation team confirmed that the HCAs had access to Mr. M's cell at night.

8.8 On 23 June 2022, Mr. M's condition deteriorated further. The medical records showed that a Palliative Care Nurse visited Mr. M on 24, 25 and 26 June 2022. Prison Nurses monitored and attended to Mr. M at intervals day and night. A HCA attended to Mr. M's hygiene needs on a 24 hour basis for the days preceding his passing, all of which were recorded in a journal.

8.9 Nurse B noted on the Prison Healthcare Management System (PHMS) that members of Mr. M's family visited Mr. M and thanked the healthcare team for their kindness.

8.10 Nurse A recorded on the PHMS that at 03:00 he received a call from the Class Officer notifying them that the HCA reported that Mr. M was not breathing. Nurse A attended the cell, found no pulse and informed Dr. A.

8.11 Dr. A recorded on the PHMS that death was pronounced at 08:09 on 27 June 2022.

9. Compassionate Visit

9.1 Due to Mr. M's poor prognosis, prison management facilitated a compassionate visit for Mr. M's NoK. On 25 June 2022, Chaplain B made contact with Mr. M's wife and arranged a compassionate visit for the following day, 26 June 2022 at 12:30, for one hour. This visit was arranged to coincide with the period when other prisoners on the landing would be locked back in their cells for lunch. In order to gain access to the prison, the NoK was advised to bring identification.

9.2 On 26 June 2022, the NoK failed to arrive to the prison at the scheduled time. The NoK arrived 30 minutes late at 13:00. The NoK was accompanied by her daughter and daughter-in-law but they did not bring identification and were not permitted entry to the prison.

9.3 Chief Officer (CO) A made contact with the NoK in the early afternoon and was advised that their car had broken down on the way to the prison and they omitted to bring the identification with them when they changed vehicles. CO A rearranged the compassionate visit for 16:30 on 26 June 2022.

9.4 Chaplain B met with the family at Mr. M's cell. Prison officers supervised the visit from outside the cell door. Chaplain B stepped out of the cell to afford the family some private time with Mr. M. The Chaplain reported joining the family in the cell before they departed, to say some payers together. The NoK departed the prison at 17:25.

9.5 CO A reported meeting the NoK before and after their visit with Mr. M and recorded that the NoK stated that "*while she was upset she expressed her gratitude for the opportunity to say her final goodbyes*".

9.6 The OIP wish to commend CO A and Chaplain B for their compassion shown and efforts made in arranging and rearranging the compassionate visit for the NoK.

10. Chaplaincy

10.1 Chaplain A stated that he had administered Last Rites, including prayers and anointing Mr. M on 24 June 2022.

10.2 On 26 June 2022, Chaplain A informed Mr. M's son, who was being held in the same prison, that his father was extremely ill with a short time to live.

10.3 Chaplain A reported they were notified of the passing of Mr. M at 04:15 on 27 June 2022 by Assistant Governor A. The Chaplain rang the NoK at 05:18 to inform her that her husband had passed.

10.4 At breakfast unlock on 27 June 2022, the Chaplain met with Mr. M's son and informed him that his father had passed.

11. Critical Incident Review Meeting

11.1 On 27 June 2022, a Critical Incident Review Meeting[2] was convened and chaired by Governor A, attended by CO A, CO B, CNO A, Doctor A, Doctor B and PCO[3] A (minutes).

11.2 The attendees were provided with an overview of Mr. M's time in custody. Doctor A reported that Mr. M was a terminally-ill patient who was deemed unsuitable for treatment and was receiving palliative care during his time in the Midlands Prison.

11.3 The doctor's report was corroborated by CNO A who stated that Mr. M was unwell from the time of his committal.

11.4 Governor A outlined the sequence of events as provided by ACO A.

11.5 CO A reported on the arrangements made to facilitate the compassionate visit by the family.

11.6 Governor A expressed his appreciation "*for the professionalism from all disciplines and healthcare staff involved in the care of Mr. M.*"

12. Recommendations

12.1 The Office of the Inspector of Prisons has made no recommendations.

13. Support Organisations

13.1 Those who are affected by a death in custody can obtain assistance or advice from a number of charities and support groups. The Office of the Inspector of Prisons has an information pamphlet for relatives and friends of someone who dies in the custody of a prison. Further information can be found on the OIP website at www.oip.ie.

[2] This meeting is between prison management and all prison staff who were involved in the incident of who may have relevant information. These are conducted to identify good practice, potential shortcomings and to address any welfare needs. In this case no issues of concern were raised or identified.
[3] PCO – Prison Clerical Officer who attends to take the minutes of a CIRM.